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HOME-BASED CASE MANAGEMENT SERVICES

EXECUTIVE SUMMARY

SERVICE INTRODUCTION

Home-based case management services are client-centered case management and social work activities that focus on care for people living with HIV who are functionally impaired and require intensive home and/or community-based care. Services are conducted by qualified Registered Nurse (RN) case managers and Master's degree-level social workers who facilitate optimal health outcomes for functionally impaired people living with HIV through advocacy, liaison and collaboration.

Home-based case management services may include:

- ◆ Assessment
- ◆ Service planning
- ◆ Attendant care
- ◆ Homemaker services
- ◆ Medical case management
- ◆ Care coordination
- ◆ Psychosocial case management
- ◆ Mental health therapy

The goals of home-based case management for functionally impaired people living with HIV include:

- ◆ Assessing and facilitating in-home services
- ◆ Helping clients locate needed health care and supportive services
- ◆ Helping service providers coordinate care for clients
- ◆ Helping clients understand and manage their medical diagnoses, including co-morbidities and other health-related diagnoses that impact HIV care treatment
- ◆ Educating clients on reducing risks for HIV infection
- ◆ Helping patients adhere to medical regimens and drug therapies
- ◆ Helping clients transition appropriately to self-management and care
- ◆ Providing appropriate, quality, cost-effective care

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

Home-based case management services are provided by an RN in good standing and licensed in California by the State Board of Registered Nursing. Social workers providing home-based case management services will hold a Master's degree in social work or related field from an accredited program.

Home health agencies that provide skilled nursing will be qualified and licensed by the California Department of Public Health (CDPH) as a home health agency (HHA).

Home care organizations (HCOs) that provide attendant care and/or homemaker services are not required to be licensed by the CDPH, but must maintain a current business license.

SERVICE CONSIDERATIONS

General Considerations: Home-based case management will be patient-centered, respecting the inherent dignity of the patient. All home-based case management will be client-driven, aiming to increase a patient's sense of empowerment, self-advocacy and medical self-management, as well as enhance the overall health status of people living with HIV. All home-based case management will be culturally and linguistically appropriate.

Outreach: Programs providing home-based case management services will conduct outreach activities to educate potential clients, HIV services providers and other supportive service organizations about the availability and benefits of home-based case management services.

Intake: Client intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, client intake will be completed in the first contact with the potential client

Assessment: Assessment is the systematic and continuous collection of data and information about the client and his or her need for home-based case management. Assessment includes a complete health history as well as supplemental information for other health and social service professionals. Assessment is completed in a cooperative, interactive, face-to-face interview process.

Service Plan: The nursing and case management team will develop and implement a comprehensive, current individualized service plan for each client. The client, or client's representative, should be an active participant in developing the service plan.

Implementation and Evaluation of Service Plan: Home-based case management service plan implementation and evaluation involve ongoing contact and interventions with (or on behalf of) the client to ensure goals are addressed that work towards improving a patient's health, restoring health maintenance or restoring health status.

Attendant Care: As necessary, attendant care will be provided under the direct supervision of a licensed nurse and provide services for persons living with HIV who require intensive home- and/or community-based services.

Homemaker Services: As necessary and under direction of a licensed nurse, homemaker services will be provided to clients living with HIV who require intensive home and/or community-based services. Homemaker services consist of general household activities performed when the client is unable to manage homecare for himself or herself.

HIV Prevention, Education and Counseling: RN case managers and social workers will provide health information and education to clients, their family members or other supportive persons regarding HIV prevention, transmission and risk behavior management.

Referral and Coordination of Care: Programs offering home-based case management services will collaborate with other agencies to provide referral to the full spectrum of HIV-related services.

Retention: Programs shall strive to retain clients in home-based case management. To ensure continuity of service and patient retention, programs will be required to establish a broken appointment policy.



*Services
help clients
who are
functionally
impaired.*

Case Conference: A case conference will be held every 60 days for each client, attended by, at minimum, the RN case manager and social worker. Case conferencing provides an opportunity to review the service plan and revise it according to client need.

Case Closure: Case closure is a systematic process for disenrolling clients from home-based case management. The process includes formally notifying clients of pending case closure and completing a case closure summary to be kept on file in the client record.

Policies, Procedures and Protocols: Programs providing home-based case management will have written policies, procedures and protocols, including eligibility criteria, for all services to be provided in accordance with Case Management Program (CMP) protocols.

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all home-based case management staff will be able to provide linguistically and culturally appropriate care to people living with HIV and to complete documentation as required by their positions. Home-based case management staff will complete an agency-based orientation before providing services.

RNs and social workers providing home-based case management services should complete DHSP's Case Management Certification Program. In addition, home-based case management staff are required to attend an annual training/briefing on available public/private benefits and available benefits specialty services. Home-based case management nurses and social workers (as appropriate) must maintain their licenses by fulfilling the financial and continuing education requirements established by their respective professional State and national boards.



HOME-BASED CASE MANAGEMENT SERVICES

SERVICE INTRODUCTION

Home-based case management services are client-centered case management and social work activities that focus on care for persons living with HIV who are functionally impaired and require intensive home- and/or community-based services. Services are conducted by qualified Registered Nurse (RN) case managers and Master's degree-level social workers who facilitate optimal health outcomes for functionally impaired people living with HIV through advocacy, liaison and collaboration.

Home-based case management services may include:

- ◆ Assessment
- ◆ Service planning
- ◆ Attendant care
- ◆ Homemaker services
- ◆ Medical case management
- ◆ Care coordination
- ◆ Psychosocial case management
- ◆ Mental health therapy

All programs will use available standards of care to inform clients of their services and will provide services in accordance with legal and ethical standards. Maintaining confidentiality is critical and its importance cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

The goals of home-based case management include:

- ◆ Assessing and facilitating in-home services for functionally impaired people living with HIV
- ◆ Helping clients locate needed health care and supportive services
- ◆ Helping service providers coordinate care for clients
- ◆ Helping clients understand and manage their medical diagnoses, including co-morbidities and other health-related diagnoses that impact HIV care treatment
- ◆ Educating clients on reducing risks for HIV infection
- ◆ Helping patients adhere to medical regimens and drug therapies
- ◆ Helping clients transition appropriately to self-management and care
- ◆ Providing appropriate, quality, cost-effective care



*Services are
provided by
RN case
managers.*

Recurring themes in this standard include:

- ◆ Home-based case management will respect the dignity and self-determination of patients.
- ◆ Services will be delivered to support and enhance a patient's self-sufficiency.
- ◆ All services will be based on a collaborative comprehensive assessment, around which service plans and implementation activities are developed
- ◆ Ongoing monitoring and updating of service plans will be an integral part of home-based case management.

The Los Angeles County Commission on HIV and the Division of HIV and STD Programs (DHSP)—formerly referred to as the Office of AIDS Programs and Policy—have developed this standard of care to set minimum quality expectations for service provision and to guarantee clients consistent care, regardless of where they receive services in the County.



This document represents a synthesis of published standards and research, including:

- ◆ *Case Management and Home/Community-Based Care Services Contract Exhibit*, Office of AIDS Programs and Policy
- ◆ *Medical Case Management Standard of Care*, Los Angeles Commission on HIV
- ◆ *Medical Case Management Service Description*, Office of AIDS Programs and Policy
- ◆ *HIV/AIDS Psychosocial Case Management Standard of Care*, Case Management Task Force of Los Angeles County, 2004
- ◆ *Medical Outpatient-Specialty Standard of Care*, Los Angeles County Commission on HIV
- ◆ Standards of care developed by several other Ryan White Part A Planning Councils. Most valuable in the drafting of this standard were Baltimore, 2004; Las Vegas; and San Antonio, 2005

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

Home-based case management services are provided by an RN in good standing and licensed in California by the State Board of Registered Nursing. Nurses will practice with the Scope of Practice as outlined in the California Business and Professional Code, Section 2725. (See www.rn.ca.gov for more information.)

Social workers providing home-based case management services will hold a Master's degree in social work or related field from an accredited program.

Home health agencies that provide skilled nursing and other therapeutic services will be qualified and licensed by the California Department of Public Health (CDPH) as a home health agency (HHA).

Home care organizations (HCOs) that provide attendant care and/or homemaker services are not required to be licensed by the CDPH, but must maintain a current business license.

RNs and social workers providing home-based case management services should successfully complete DHSP's HIV Case Management Certification Program and participate in all required recertification activities and training.

DEFINITIONS AND DESCRIPTIONS

Assessment is a comprehensive evaluation of each client's physical, psychological, social, environmental and financial status to determine the type and level of service needs. Assessments will be performed in accordance with guidelines set forth by the California Department of Public Health (CDPH) Case Management Program (CMP).

Attendant care includes the provision of non-medical personal care by a home health aide or nurse assistant certified by the CDPH. Services are provided under the direct supervision of a licensed nurse.

Home care organization (HCO) is an entity that provides attendant care and/or homemaker services only. HCOs are not licensed by the CDPH and are not subject to State-issued service standards or criteria.

Home health agency (HHA) is a public or private entity that provides skilled nursing and other therapeutic services to clients in their place of residence under a treatment plan prescribed by an attending physician. HHAs must be qualified and licensed by the CDPH as a home health agency.

Homemaker services include general household activities performed when the client is unable to manage home care for himself or herself at home. Services are provided under the direct supervision of a licensed nurse.

Registered Nurse (RN) case management services include the provision of comprehensive medical case management for people living with HIV who require intensive home and/or community-based services.

Service plan is a written document identifying a client's problems and needs, intended interventions and expected results, including short- and long-range goals written in measurable terms.

Social work case management services include the provision of comprehensive social work case management services including, but not limited to, psychosocial, financial, housing and related concerns for people living with HIV who require intensive home- and/or community-based services.

Social workers, as defined in this standard, are individuals who hold a Master's degree in social work or related field from an accredited program.

HOW SERVICE RELATES TO HIV

At the end of 2013, approximately 60,050 people were estimated to be living with HIV infection in Los Angeles County. Los Angeles County comprises 40% of the total AIDS cases in the State of California (Epidemiologic Profile of HIV in Los Angeles County, 2013).

Case management services have been shown to be an essential component in the comprehensive care of people living with HIV (Mitchell & Linsk, 2001). The effect of case managers is felt both directly and through their role as gatekeepers to a variety of other supportive services (Messerli et al., 2002).



Homemaker services include laundry and ironing.

Connecting clients to resources is time-consuming and complex, often involving a mix of advocacy and mediation (Chernesky & Grube, 2000). Even brief interventions by case managers have been associated with significantly higher rates of linkages to HIV care services (Gardner et al., 2005). Clients who have contact with case managers report less unmet need for income assistance, health insurance, home care and emotional counseling (Katz et al., 2001).

In addition to linking clients to services, case managers help their clients develop personal support systems, often serving as the center of that support (Chernesky & Grube, 2000). A recent Canadian study demonstrated that case management services have reduced client isolation and improved health-related quality of life (Crook et al., 2005).

Case management is integral to medical care. Messeri and colleagues (2002) found that case managers strengthen connections to care by informing clients of the availability of appropriate medical resources, educating them about their benefits and serving as advocates in coordinating medical services and accessing insurance to cover their costs (Messeri et al., 2002). This same New York City study found formal client assessment, the development of a care plan and assistance in securing public benefits to be key factors in a significantly increased likelihood of a client's entering and maintaining medical care (Messeri et al., 2002).

Case management services are important in promoting adherence to treatment (Office of HIV Planning, 2002). Case managers help patients overcome fears about medical treatment, adhere to medication regimens, and advocate for themselves with physicians (Katz, et al., 2001). Gasiorowicz and colleagues (2005) found that prevention-focused case management significantly decreased reported risk transmission behaviors, including unprotected vaginal intercourse, insertive anal intercourse, and needle-sharing.

SERVICE COMPONENTS

Home-based case management services are client-centered case management and social work activities for people living with HIV who are functionally impaired and require intensive home- and/or community-based services. Services are conducted by qualified RN case managers and Master's degree-level social workers who facilitate optimal health outcomes for these individuals through advocacy, liaison and collaboration.

Programs will maintain participation in the State's CMP and abide by the requirements, standards, protocols and procedures established by the State Office of AIDS as they now exist or shall exist at any future time, and in accordance with HIV/AIDS home-based case management standards and protocols.

Home-based case management will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by nurse case managers and other professionals to whom they are referred. Such patient-practitioner discussions are relationship-building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen. Case managers are directed to patient-oriented HIV/AIDS care and prevention websites such as Project Inform (www.projectinform.org) and The Body (www.thebody.com) for more information about discussing HIV/AIDS from a patient-centered approach.

Home-based case management will be client-driven, aiming to increase a patient's sense of empowerment, self-advocacy and medical self-management, as well as enhance the overall health status of people living with HIV. All home-based case management will be culturally and linguistically appropriate to the target population (see Program Requirements and Guidelines in the Standards of Care Introduction).

Home-based case management services may include:

- ◆ Assessment
- ◆ Service planning
- ◆ Attendant care
- ◆ Homemaker services
- ◆ Medical case management
- ◆ Care coordination
- ◆ Psychosocial case management
- ◆ Mental health therapy

OUTREACH

Programs providing home-based case management services will conduct outreach activities to educate potential clients, HIV services providers and other supportive service organizations about the availability and benefits of these services for functionally impaired people living with HIV in Los Angeles County who require intensive home- and/or community-based services. Programs will work in collaboration with HIV primary health care, support services providers and case management programs.

STANDARD	MEASURE
Home-based case management programs will outreach to potential patients and providers.	Outreach plan on file at provider agency.

INTAKE

It is unlikely that a client's point of entry into the HIV service system will be through home-based case management; however, if a client's first contact with the HIV continuum of care is through this service, programs providing case management, home-based case management services will be responsible for client intake.

Client intake determines eligibility and includes demographic data, emergency contact information and/or next of kin and eligibility documentation. When possible, client intake will be completed in the first contact with the potential client. The complete intake process, including registration and eligibility, is required for every client at his or her point of entry into the service system. If an agency or other funded entity has the required information and documentation on file in the agency record for that client or in the countywide data management system, further intake is not required.

In the intake process and throughout case management, home-based service delivery, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information

(specification should indicate the type of information that can be released).

As part of the intake process, the client file will include the following information (at minimum):

- ◆ Written documentation of HIV diagnosis
- ◆ Proof of Los Angeles County residency
- ◆ Verification of financial eligibility for services
- ◆ Date of intake
- ◆ Client name, home address, mailing address and telephone number
- ◆ Emergency and/or next of kin contact name, home address and telephone number

Required Forms: Programs must develop the following forms in accordance with State and local guidelines.

Completed forms are required for each client:

- ◆ Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- ◆ Limits of Confidentiality (Confidentiality Policy)
- ◆ Consent to Receive Services
- ◆ Client Rights and Responsibilities
- ◆ Client Grievance Procedures

STANDARD	MEASURE
Intake process will begin during first contact with client.	Intake tool, completed and in client file, to include (at minimum): <ul style="list-style-type: none"> • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contract name, home address and telephone number
Confidentiality Policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
Consent for Services will be completed.	Signed and dated Consent in client file.
Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.

ASSESSMENT

Assessment is the systematic and continuous collection of data and information about the client and his/her need for home-based case management. Assessment includes a complete health history as well as supplemental information for other health and social service professionals. The assessment organizes and synthesizes client information from many sources, making the information more accessible to the client and the treatment team.

Assessment is completed in a cooperative, interactive, face-to-face interview process. The assessment must be completed within 30 days following intake and will document the client's needs, along with mutual decisions made regarding needs and services. Assessments will be updated on a continuous basis, but no less than once every 60 days.

Assessments will include the following (at minimum):

- ◆ Comprehensive medical information, including:
 - Client's medical status, including a health systems review to gather history of HIV disease and other related illnesses, relevant medical and psychosocial information
 - Description of current physiological and psychosocial status
 - Current medical care, including names of treating physicians, eligibility and participation in other HIV-related services
 - Medical diagnoses and likely complications
 - Tests, treatment regimens and possible pharmacological complications
 - Assessment of success and problems with adhering to medication regimens and medical appointments
 - Client's and his or her social affiliates' risks for HIV transmission, need for health education, risk reduction education and support
- ◆ Client's level of understanding and educational needs related to diagnosis, treatment options, prognosis, financial resources
- ◆ Assessment of psychological adjustment and coping mechanisms
- ◆ Consultation (or documented attempts) with client's health care and social service providers who are actively involved with the client to gather additional data necessary for assessment
- ◆ Assessment of need for home health care

In addition, when indicated, a client's primary support person should be assessed for his or her HIV knowledge (including prevention and risk reduction behaviors), health status, expectation and ability to serve as client's primary caretaker.

STANDARD	MEASURE
Assessments will be completed within 30 days following intake. Updates to the assessment will be done on a continuous basis, but no less than once every 60 days.	Assessment or update on file in client record to include: <ul style="list-style-type: none"> • Date • Signature and title of staff person • Comprehensive medical information (detailed above) • Client's educational needs related to treatment • Assessment of psychological adjustment and coping • Consultation (or documented attempts) with health care and related social service providers • Assessment of need for home-health care services A client's primary support person should also be assessed for ability to serve as client's primary caretaker.

SERVICE PLAN

The nursing and case management team will develop and implement a comprehensive, current individualized service plan for each client.

The plan will document (at minimum):

- ◆ Client's need for home health care
- ◆ Frequency of home health care services
- ◆ Subcontractor selected to provide these services

The client or client's representative should be an active participant in developing the service plan. All interested parties should agree to the plan before beginning implementation.

Service plans will include:

- ◆ Name of client, RN case manager and social worker
- ◆ Date and signature of case manager
- ◆ Documentation that the service plan has been discussed with the client or representative
- ◆ Description of flexible short- and long-term goals
- ◆ Steps to be taken by client, RN case manager, social worker and others to accomplish goals
- ◆ Timeframe by which goals are expected to be met
- ◆ Number and type of client contacts based on service plan needs:
 - RN case manager – at least one face-to-face reassessment every 60 days; clients who are in a medical crisis or who are at the end stages of their lives may receive additional visits, as necessary
 - Social worker – at least one face-to-face reassessment every 60 days
- ◆ Concrete recommendations on how to implement service plan
- ◆ Contingencies for anticipated problems or complications

STANDARD	MEASURE
Home-based case management service plans will be developed in conjunction with the patient.	Home-based case management service plan on file in client record to include: <ul style="list-style-type: none"> • Name of client, RN case manager and social worker • Date/signature of RN case manager and/or social worker • Documentation that plan has been discussed with client • Client goals, outcomes and dates of goal establishment • Steps to be taken to accomplish goals • Timeframe for goals • Number and type of client contacts • Recommendations on how to implement plan • Contingencies for anticipated problems or complications

IMPLEMENTATION AND EVALUATION OF SERVICE PLAN

Home-based case management service plan implementation and evaluation involve ongoing contact and interventions with (or on behalf of) the client to ensure goals are addressed that work towards improving a patient's health, restoring health maintenance or restoring health status.

In the implementation and evaluation phase, RN case managers and social workers are responsible for (at minimum):

- ◆ Providing linked referrals, client advocacy and appropriate interventions based on the intake, assessment and service plan
- ◆ Monitoring changes in the client's condition or circumstances, updating/revising the nursing case management plan and providing appropriate interventions and linked referrals
- ◆ Ensuring that care is coordinated among the client, caregivers and service providers
- ◆ Conducting ongoing monitoring and follow-up with clients and providers to confirm completion of referrals, service acquisition, maintenance of services and adherence to services
- ◆ Advocating on behalf of clients with other service providers
- ◆ Empowering clients to develop and use independent living skills and strategies

- ◆ Helping clients resolve any barriers to completing referrals and accessing or adhering to services
 - ◆ Actively following up on established goals in the service plan to evaluate patient progress and determine appropriateness of services
 - ◆ Maintaining ongoing client contact
 - ◆ When the team is aware of client hospitalization, being actively involved during hospitalization or following up within the next business day after discharge (when the team is aware of discharge date)
 - ◆ Actively following up with clients who have missed a case management or social work appointment within one business day. [If follow-up activities are not appropriate or cannot be conducted within the prescribed time period, case managers will document reason(s) for the delay.]
 - ◆ Ensuring that State guidelines about ongoing eligibility (such as medical care requirements, safe home setting, continued medical need, etc.) are followed
- Current dated and signed progress notes, detailing activities related to implementing and evaluating, will be kept on file in the patient record.



*Attendant
care
includes
light house-
keeping.*

The following documentation is required (at minimum):

- ◆ Description of all client contacts, attempted contacts and actions taken on behalf of the client
- ◆ Date and type of contact
- ◆ Description of what occurred during the contact
- ◆ Changes in the client's condition or circumstances
- ◆ Progress made towards achieving goals identified in the service plan
- ◆ Barriers identified in goal process and actions taken to resolve them
- ◆ Linked referrals and interventions provided
- ◆ Current status and results of linked referrals and interventions
- ◆ Barriers identified in completing linked referrals and actions taken to resolve them
- ◆ Time spent with, or on behalf of, the client
- ◆ RN case manager's or social worker's signature and professional title

STANDARD	MEASURE
RN case managers and social workers will: <ul style="list-style-type: none"> • Provide referrals, advocacy and interventions based on the intake, assessment and case management plan • Monitor changes in the client's condition • Update/revise the case management plan • Provide interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up • Advocate on behalf of clients • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on plan goals • Maintain ongoing contact based on need • Be involved during hospitalization or follow-up after discharge from the hospital • Follow up missed appointments by the end of the next business day • Ensuring that State guidelines regarding ongoing eligibility are followed 	Signed, dated progress notes on file to detail (at minimum): <ul style="list-style-type: none"> • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward plan goals • Barriers to plan and actions taken to resolve them • Linked referrals and interventions and current status/ results of same • Barriers to referrals and interventions/actions taken • Time spent • RN case manager's or social worker's signature and title

ATTENDANT CARE

As necessary, attendant care will be provided under the direct supervision of a licensed nurse and provide the following services for people living with HIV who require intensive home- and/or community-based services:

- ◆ Assisting clients with personal care (bathing, grooming, oral hygiene, skin care, dressing, etc.) and comfort measures
- ◆ Monitoring and recording vital signs
- ◆ Changing bed linen as necessary
- ◆ Assisting with prescribed exercises which the client and attendant have been taught to perform by appropriate health professionals
- ◆ Assisting clients in and out of bed and with ambulatory movement
- ◆ Assisting clients to the bathroom and/or with bedpan use
- ◆ Assisting with ordinarily self-administered medications that have been specifically ordered by a physician
- ◆ Performing light housekeeping chores to maintain a clean environment
- ◆ Changing dressings and bandages
- ◆ Shopping and preparing nutritious meals as well as feeding a client when necessary
- ◆ Accompanying clients to medical appointments
- ◆ Reporting changes in clients' conditions and needs
- ◆ Maintaining clinical notes in accordance with clients' service plan

Programs will subcontract with a minimum of three licensed home health agencies or home care organizations to provide attendant care. This approach will ensure that the client or representative has a choice of providers when possible, based upon the availability of participating services providers in a given geographical area. Programs should be familiar with the contracting agency's policies regarding the education and orientation of staff with regards to HIV, mandated reporting and risk management.

STANDARD	MEASURE
Attendant care will be provided under the supervision of a licensed nurse, as necessary.	Record of attendant care on file in client chart.
When possible, programs will subcontract with at least HCOs or HHCs.	Contracts on file at provider agency.

HOMEMAKER SERVICES

As necessary and under direction of a licensed nurse, homemaker services will be provided to clients living with HIV who require intensive home- and/or community-based services. Such services will be monitored at least every 60 days. Homemaker services consist of general household activities performed when the client is unable to manage homecare for himself or herself.

Services may include (but are not limited to):

- ◆ Sweeping
- ◆ Vacuuming
- ◆ Washing and waxing floors
- ◆ Washing kitchen counters and sinks
- ◆ Cleaning the oven and stove
- ◆ Cleaning and defrosting the refrigerator
- ◆ Cleaning the bathroom

- ◆ Taking out the garbage
- ◆ Dusting and picking up
- ◆ Changing bed linen
- ◆ Meal preparation and clean-up
- ◆ Laundry, ironing and folding and putting away laundry
- ◆ Shopping and errands
- ◆ Storing food and supplies
- ◆ Accompanying clients to medical appointments when appropriate
- ◆ Boiling and storing tap water
- ◆ Other services as necessary

Programs will subcontract with a minimum of three licensed home health agencies or home care organizations to provide homemaker services. This will ensure that the client or representative has a choice in providers when possible, based upon the availability of participating services providers in a given geographical area. Programs should be familiar with the contracting agency's policies regarding the education and orientation of staff with regards to HIV, mandated reporting and risk management.

STANDARD	MEASURE
Homemaker services will be provided under the supervision of a licensed nurse, as necessary.	Record of homemaker services on file in client record.
Homemaker services will be monitored at least once every 60 days.	Record of monitoring on file in the client record.
When possible, programs will subcontract with at least HCOs or HHCs.	Contracts on file at provider agency.

HIV PREVENTION, EDUCATION AND COUNSELING

RN case managers and social workers will provide health information and education to clients, their family members or other supportive persons regarding HIV prevention, transmission and risk behavior management.

RN case managers and social workers will:

- ◆ Screen clients for risk behaviors
- ◆ Communicate prevention messages to clients
- ◆ Discuss sexual practices and drug use with clients
- ◆ Positively reinforce changes to safer behavior
- ◆ Refer clients for substance abuse treatment
- ◆ Facilitate partner notification, counseling and testing
- ◆ Identify and treat other sexually transmitted diseases

Education and counseling will be provided within the scope of the RN case manager's license and the guidelines and recommendations described in "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV," *Morbidity and Mortality Weekly Report*, July 18, 2003/Vol.52/No.RR-12). If an RN case manager is unable to directly provide such education and counseling, patients will be referred to appropriately credentialed and/or licensed professionals.

STANDARD	MEASURE
RN case managers and social workers will provide prevention and risk management education and counseling to all clients, partners and social affiliates.	Record of services on file in client medical record.

STANDARD	MEASURE
Case managers and social workers will: <ul style="list-style-type: none"> • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug use • Reinforce safer behavior • Refer for substance abuse treatment • Facilitate partner notification, counseling and testing • Identify and treat sexually transmitted diseases 	Record of prevention services on file in client record.
When indicated, clients will be referred to appropriately credentialed/licensed professionals for prevention education and counseling.	Record of linked referral on file in client record.

REFERRAL AND COORDINATION OF CARE

Programs offering home-based case management services will collaborate with other agencies to provide referral to the full spectrum of HIV-related services.

Because resource referral and coordination is such a vital component of home-based case management services, programs must maintain a comprehensive list of target providers (both internal and external), including, but not limited to, the HIV LA Resource Directory, for the full spectrum of HIV-related services. Nurse case managers and social workers will maintain knowledge of local, State and federal services available for people living with HIV. Referrals to services, including mental health treatment, treatment advocacy, peer support, and dental treatment, will also be made as indicated. Because public/private benefits issues change frequently and are especially complex, special attention must be given to appropriate referral or coordination of public/private benefits specialty services.

Programs will develop written procedures and protocols for referring clients to other health and social services. Referral systems must include a process for tracking and monitoring referrals and their results.

STANDARD	MEASURE
Home-based case management programs will maintain a comprehensive list of providers for full spectrum HIV-related service referrals.	Referral list on file at provider agency.
Home-based case management programs will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding detailing collaborations on file at provider agency.
Home-based case management programs will develop procedures and protocols for referrals.	Written procedures and protocols on file at provider agency that includes process for tracking and monitoring referrals.

CASE CONFERENCE

A case conference will be held every 60 days for each client, attended by, at minimum, the RN case manager and social worker. Case conferencing provides an opportunity to review the service plan and revise it according to client need. Such review and revision will be documented in writing every 60 days and include the names and titles of those participating in the review. Client or representative input should also be sought for this review and recorded in the case conference documentation.

STANDARD	MEASURE
Case conferences held by RN and social worker (at minimum) will review and revise service plans at least every 60 days. Client or representative feedback will be sought.	Documentation of case conferences on file in client record to include names and titles of those participating in the review and client or representative input.

PATIENT RETENTION

Programs shall strive to retain clients in home-based case management services. To ensure continuity of service and patient retention, programs will be required to establish a broken appointment policy. Follow-up strives to maintain a client's participation in care and can include telephone calls, written correspondence and/or direct contact. Such efforts shall be documented in the progress notes within the client record.

STANDARD	MEASURE
Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
Programs will provide regular follow-up procedures to encourage and help maintain a client in home-based case management.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: <ul style="list-style-type: none"> • Telephone calls • Written correspondence • Direct contact

CASE CLOSURE

Case closure is a systematic process for disenrolling clients from home-based case management services. The process includes formally notifying clients of pending case closure and completing a case closure summary to be kept on file in the client record. All attempts to contact the client and notifications about case closure will be documented in the client file, along with the reason for case closure.

Cases may be closed when the client:

- ◆ Has achieved his or her home-based case management service plan goals
- ◆ Relocates out of the service area
- ◆ Has had no direct program contact in the past six months
- ◆ Is ineligible for the service
- ◆ No longer needs the service
- ◆ Discontinues the service
- ◆ Is incarcerated long term
- ◆ Uses the service improperly or has not complied with the client services agreement
- ◆ Has died

When appropriate, case closure summaries will include a plan for client's continued success and ongoing resources to be used.

At minimum, case closure summaries will include:

- ◆ Date and signature of RN case manager and/or social worker
- ◆ Date of case closure
- ◆ Status of the service plan
- ◆ Status of primary health care and support service utilization
- ◆ Referrals provided

◆ Reasons for disenrollment and criteria for re-entry into services

STANDARD	MEASURE
Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client record
Home-based case management cases may be closed when the client: <ul style="list-style-type: none"> Has achieved his or her home-based case management service plan goals Relocates out of the service area Has had no direct program contact in the past six months Is ineligible for the service No longer needs the service Discontinues the service Is incarcerated long term Uses the service improperly or has not complied with the client services agreement Has died 	Case closure summary on file in client chart to include: <ul style="list-style-type: none"> Date and signature of RN case manager and/or social worker Date of case closure Service plan status Status of primary health care and service utilization Referrals provided Reason for closure Criteria for re-entry into services

POLICIES, PROCEDURES AND PROTOCOLS

Programs providing home-based case management services will have written policies, procedures and protocols, including eligibility criteria, for all services to be provided in accordance with the CDPH CMP protocols

STANDARD	MEASURE
Home-based case management programs will have written policies, procedures and protocols, including eligibility criteria.	Policies, procedures and protocols on file at provider agency.

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all home-based case management staff will be able to provide linguistically and culturally appropriate care to people living with HIV and complete documentation as required by their positions. Home-based case management staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding patient confidentiality and HIPAA regulations.

RN case managers will be RNs in good standing and licensed by the California Board of Registered Nursing. An RN providing case management services must be a graduate of an accredited nursing program with a Bachelor of Science in Nursing (BSN) or two-year Nursing Associate's degree. Prior to employment, BSNs and RNs with Associate degrees must have at least two years' post-degree experience and one year's experience in community or public health nursing. The RN must practice within the scope of practice defined in the California Business & Professional Code, Section 2725 RN Scope of Practice (www.rn.ca.gov).

RN case managers will practice in accordance with applicable State and federal regulations. Case managers will uphold the Code of Ethics for Nurses with Interpretive Statements (2001: ANA Board of Directors and Congress of Nursing Practice and Economics). Additionally, medical case managers will comply with special Codes of Ethics or HIV/AIDS

Policies from their national professional associations (see www.nursingworld.org for ANA Position Statements and www.anacnet.org for Policy Position Statements and Resolutions.)

Social workers providing home-based case management services will hold a Master's degree in social work (MSW) or related degree from an accredited social work program. Social workers will practice in accordance with applicable State and federal regulations, uphold the Social Work Code of Ethics (<http://www.naswdc.org/pubs/code/default.asp>) and comply with the staff development and education requirements noted below.

It is recommended that RNs and social workers providing home-based case management services will complete DHSP's Case Management Certification Program and recertifications and requisite training (as appropriate). In addition, home-based case management staff are required to attend an annual training/briefing on available public/private benefits and available benefits specialty services. RNs are encouraged to pursue registration as an AIDS Certified Registered Nurse offered by the Association of Nurses in AIDS Care and the HIV/AIDS Nursing Certification Board (see www.anacnet.org). In addition, RNs are required to maintain current cardiopulmonary resuscitation (CPR) certification in accordance with the Business and Professions Code of California, Article 2. *Scope of Regulation, number 2725, Legislative Declaration; Practice of Nursing; Functions.*

Staff Development and Education: Home-based case management nurses and social workers (as appropriate) must maintain their licenses by fulfilling the financial and continuing education requirements established by their respective professional State and national boards.

In selecting continuing education courses to fulfill licensing requirements, RNs and social workers are encouraged to select a majority of courses related to their respective scopes of practice and courses related to services within the HIV/AIDS continuum's primary health care core.

Client Care-Related Supervision: Supervision is recommended for all home-based case management staff to provide guidance and support. Such patient care-related supervision may be conducted in individual or group/multidisciplinary team case conference formats.

Client care-related supervision will address clients' medical and psychosocial issues and concerns, provide general clinical guidance and help to develop follow-up plans for RN case managers and social workers. Supervision will assist in problem-solving related to clients' progress towards goals detailed in the service plan and to ensure that high-quality services are being provided.

It is recommended that programs ensure that each active client is discussed at a minimum of one time per six-month period. For each client discussed, the supervisor should address the identified medical and psychosocial issues and concerns, provide appropriate guidance and follow-up plan, and verify that guidance provided and follow-up plan has been implemented.

It is recommended that client care-related supervision include the following documentation to be kept on file in the client record:

- ◆ Date of client care-related supervision
- ◆ Supervision format (e.g., individual, group, case conference or multidisciplinary team case conference)
- ◆ Name and title of participants
- ◆ Medical and psychosocial issues and concerns identified

- ◆ Description of guidance provided and follow-up plan
- ◆ Verification that guidance provided and follow-up plan have been implemented
- ◆ Supervisor's name, title and signature

STANDARD	MEASURE
RNs providing home-based case management services will: <ul style="list-style-type: none"> • Hold a license in good standing from the California State Board of Registered Nursing • Have graduated from an accredited nursing program with a BSN or two-year nursing associate's degree • Have two years' post-degree experience and one year's community or public health nursing experience. • Practice within the scope defined in the California Business & Professional Code, Section 2725 	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Social workers providing home-based case management services will hold an MSW or related degree and practice according State and federal guidelines and the Social Work Code of Ethics..	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
RN case managers and social workers will attend an annual training/briefing on public/private benefits.	Documentation of attendance in employee files.
Staff will maintain licenses by completing continuing education requirements of their respective professional boards.	Record of continuing education in employee files at provider agency.

UNITS OF SERVICE

Unit of service: Units of service defined as reimbursement for case management, medical services are based on services provided to eligible patients.

- ◆ **Home-based case management units:** calculated in number of patient contacts
- ◆ **Attendant care/homemaker units:** calculated in number of hours of service provided

Number of patients: Patient numbers are documented using the figures for unduplicated patients within a given contract period.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BSN	Bachelor of Science in Nursing
CDPH	California Department of Public Health
CMP	Case Management Program
CPR	Cardiopulmonary Resuscitation
DHSP	Division of HIV and STD Programs
HCO	Home Care Organization
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
MSW	Master's Degree in Social Work
RN	Registered Nurse
STD	Sexually Transmitted Disease